TRICARE Fundamentals Course

Module 3

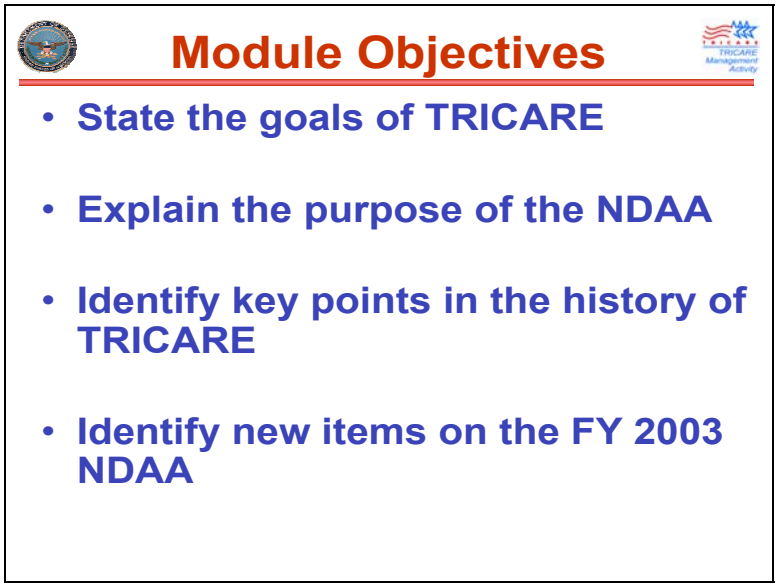
TRICARE History

Participant Guide

References

10 U.S.C.
32 CFR § 199.20
National Defense Authorization Act (NDAA)
Defense Authorization Act (DAA)
TRICARE Policy Manual 6010.47-M

Module Objectives



Where it all Began

Military Medical Care for Families

- Congressional direction – 1884
  - "Medical officers of the Army and contract surgeons shall whenever possible attend the families of the officers and soldiers free of charge"
- Congress authorizes Emergency Maternal and Infant Care Program (EMIC) – 1943
  - Provided maternity care and care of infants up to one year of age for wives and children of Service members in the lower four pay grades
  - Administered through state health departments
- Dependents Medical Care Act – December 7, 1956
  - Amendments to this Act created what would be called CHAMPUS
- Civilian Health and Medical Program for the Uniformed Services (CHAMPUS) – October 1, 1966
  - Authorized ambulatory and psychiatric care for active duty family members
  - January 1, 1967 – retirees, their family members and certain surviving family members of deceased military sponsors were brought into the program

Healthcare under CHAMPUS

- CHAMPUS—the Civilian Health and Medical Program of the Uniformed Services
  - It served the military for over 30 years as a cost-sharing program that was used to provide inpatient and outpatient care for active duty family members from civilian sources when they could not get inpatient and outpatient care through a military hospital or clinic.
  - Family members of either deceased or retired personnel or retired military personnel and their family members under the age of 65 also used CHAMPUS.
  - Space available care in MTF for all but active duty
  - Annual deductible (civilian care)
  - Cost share for every visit (civilian care)
  - Non availability statements required (civilian inpatient care)
  - No continuity of care

TRICARE

TRICARE Is Conceived

- CHAMPUS "demonstration" projects – 1980s
- CHAMPUS Reform Initiative (CRI) - 1988
  - California and Hawaii
  - Offered family members a choice of ways in which they could use their military health care benefits
  - 5 years of successful operation and high levels of patient satisfaction

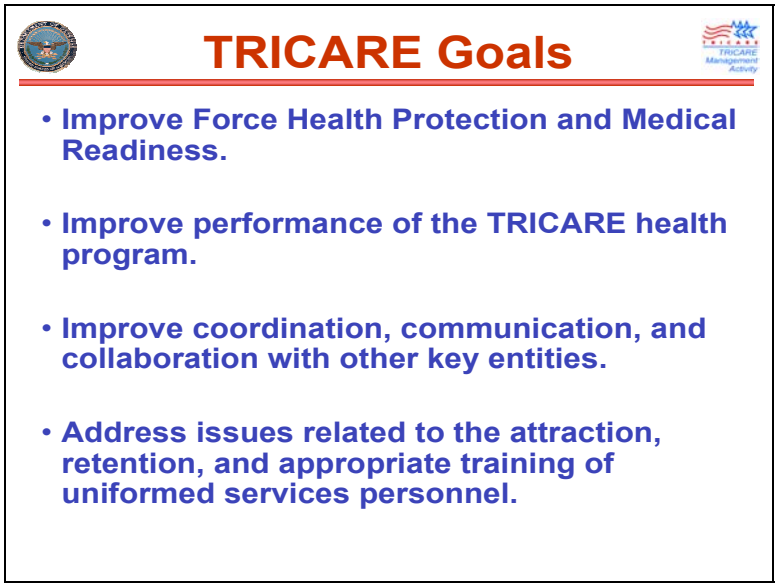
TRICARE Is Born

- Department of Defense officials, along with Congress extend and improve the CRI – 1993
- The improved program is TRICARE
- TRICARE Standard is what CHAMPUS was
  - Coverage, deductibles, cost shares, and claim-filing rules stayed the same.
  - Essentially the name just changed.
- With the switch to the TRICARE name, the three options were implemented:
  - TRICARE Prime—basically the care received in MTFs
  - TRICARE Standard—same as CHAMPUS
  - TRICARE Extra—it's TRICARE Standard with a discount due to negotiated fees with providers in a network

TRICARE Vision

TRICARE Mission

TRICARE Goals



Other areas of focus include the following:
- Improving overall access to health care for beneficiaries
- Creating a more efficient way to receive health care
- Offering enhanced services, including preventive care
- Providing choices for health care
- Providing faster, more convenient access to civilian health care
- Controlling escalating costs

TRICARE enhances medical readiness by doing the following:
- Promoting the health and well-being of our forces
- Providing preventive care and excellent medical care
- Enabling medics to maintain skills during peacetime for ultimate medical readiness during wartime
- Ensuring the Reserve component has access to quality medical care to promote their medical readiness
- Providing access to medical care for members and their families stationed away from military treatment facilities
- Taking care of family members at home so that uniformed service members can take care of the mission

Legislation

National Defense Authorization Act (NDAA)

- The NDAA is under the jurisdiction of the Senate and House Armed Services Committees.
- Title VII is TRICARE, medical and dental programs under the NDAA.
- The NDAA provides statutory direction across all DoD programs by either establishing, changing, or eliminating programs and activities:
  - Example: Preauthorization elimination. In NDAA FY 2003, Section 701 prohibits TRICARE preauthorization requirement for inpatient mental health cases where Medicare has already authorized the care and Medicare is the primary payer. Requires advance authorization for a continuation of inpatient mental health services when Medicare coverage terminates. To implement this, it needs a regulation change.
  - Preauthorization is no longer required.

Note: TRICARE is an entitlement.

In DoD, a requirement could also be viewed as a new service, is identified with an assessment of how much the new service will cost. The new requirement is then presented to the legislative staffers to develop a bill that goes before Congress for funding.

Changes to TRICARE benefits are presented from Congress through the annual NDAA process. Although, these changes are listed in the NDAA, the implementation dates are staggered due to several factors including waiting for the following:

- Public review/comment
- Funding
- Contract awards
- Policies to be written
- Contractor implementation

The staggered implementation dates allow for staffing of requirements through the TMA Directorates causing different dates between implementation and execution. One of the reasons it appears that the program has had several changes is fine-tuning of the benefits.

Other Legislation to be Familiar With

Defense Appropriations Act

- Under the Constitution, all appropriations must originate in the House of Representatives.
- Provides funding or budget authority for authorized agencies, programs, and activities.
- Establishes spending levels for programs and activities.
- Comes under the jurisdiction of the Senate and House Appropriations Committees.

32 Code of Federal Regulations (32 CFR) Part 199

- After the Authorization and Appropriations Acts become Public Law, Executive departments and agencies implement laws by publishing them in the Federal Register.
- The rules describe in detail how the statutory mandate or statutory discretion will be implemented by DoD.
- Part 199 contains the regulations published in the Federal Register relating to the CHAMPUS/TRICARE program.

Title 10

- The U.S. Code is divided into 50 titles, and Title 10 dictates Armed Forces matters.
- Chapter 55 of Title 10 covers medical and dental care.
- When laws are enacted that affect military health care, they normally amend Title 10, Chapter 55.

Title 32

- U.S. Code title that covers the National Guard

TRICARE Accomplishments

1995
Mar – First TRICARE region in Washington and Oregon (Region 11)
Oct – Nurse advice lines toll-free worldwide
Nov – Catastrophic cap reduced from $7,500 to $3,000 per year, non-active duty TRICARE Prime enrollees

1996
Jan – Expanded TRICARE/CHAMPUS breast cancer demonstration project
May – TRICARE Web site www.tricare.osd.mil stood up

1997
Jul – TRICARE Prime enrollment portable across regions
Oct – TRICARE Selected Reserve Dental Program
Oct – National Mail Order Pharmacy

1998
Feb – Retiree Dental Program
Feb – TRICARE Management Activity (TMA) established as a DoD field activity
Mar – Stopped balance billing of TRICARE Prime enrollees by non-participating providers
Mar – Limited balance billing by non-institutional providers
Jun – The final TRICARE region (Northeast) was put in place
Sep – TRICARE Senior Prime demonstration

1999
Feb – TRICARE provider payment rates equal to or higher than Medicare rates
Jun – Automatic re-enrollment for TRICARE Prime enrollees
Oct – TRICARE Prime Remote for active duty personnel
Oct – Centralized active duty claims payments

2000
Jan – Designated Beneficiary Counseling & Assistance Coordinators (BCACs) at every Lead Agent and Military Treatment Facility (MTF)
Jul – Established Debt Collection Assistance Officer (DCAO) Program
Oct – Catastrophic cap reduced from $7,500 to $3,000 per year, uniformed services retirees, their family members, and survivors using TRICARE Standard and TRICARE Extra
Oct – Enhanced coverage under the TRICARE Retiree Dental Program became effective

2001
Feb – TRICARE Dental Program, combined TRICARE Family Member Dental Plan and TRICARE Selected Reserve Dental Program
Feb – National toll-free number for TRICARE For Life
Apr – TRICARE Senior Pharmacy program was implemented
Apr – National toll-free numbers for TRICARE Senior Pharmacy and TRICARE Prime Remote for active duty and their family members
Apr – Eliminated copays for active duty family members enrolled in TRICARE Prime
Oct – TRICARE For Life – provides second payer to Medicare coverage to uniformed services retirees, their family members, and survivors who are age 65 years and over
Oct – Chiropractic care benefit for active duty uniformed services members

2002
Jan – TRICARE Transitional Health Care Demonstration Project for 60 to 120 days for family members of active duty sponsors involuntarily separated from military service under honorable conditions or family members of Reserve component members separated after serving on active duty for more than 30 days in support of contingency operations
Sep - TRICARE Prime Remote for active duty family members
Oct – TRICARE Online (tricareonline.com) implemented with symptom checker, prescription checker, personal health journal, consumer health information, disease management tools, and online appointment scheduling with their assigned MTF primary care managers for TRICARE Prime and TRICARE Plus enrollees
Dec – Awarded TRICARE Global Remote Overseas contract to International SOS Assistance, Inc., to standardize the benefit across all remote overseas regions

2003
Mar – TRICARE Mail Order Pharmacy contract to Express Scripts, Inc.
Apr –TRICARE implements patient privacy standards mandated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)
Apr – First TRICARE Fundamentals Course taught
May – TRICARE Retiree Dental Program contract to Delta Dental Plan of California
Sep - TRICARE Global Remote Overseas contract

2004
Apr – Dual-eligible Claims Processing contract to Wisconsin Physician Services Insurance Corp.
Jun – Health Care Services and Support contracts to Health Net Federal Services Inc. (North), TRIWEST Healthcare Alliance Corporation (West), and Humana Military Healthcare Services (South)
Jun – TRICARE Retail Pharmacy contract to Express Scripts, Inc.

TRICARE figures for FY 2004:

- 8.9 million beneficiaries
  - Official number comes from the Health Affairs (HA) Chief Financial Officer every summer–look for an announcement on the HA/TMA Web site
- 5.1 million TRICARE Prime enrollees
- 75 military hospitals and medical centers
- 461 medical clinics

Key Points in the FY 2004 NDAA

- SEC. 583.
  - The DoD/VA Joint Executive Committee shall submit an annual report containing recommendations to the Secretary of Veterans Affairs, Secretary of Defense, and Congress.
  - Recommendations should include the following:
    - Review existing policies, procedures and practices
    - Identify changes that promote mutually beneficial coordination, use or exchange of services and resources
    - Identify and assess further opportunities for coordination and collaboration
    - Review the plans of both Departments for acquisition of additional resources and assess the potential effect of such plans on further opportunities for the coordination and sharing of resources
    - Review implementation.

- SEC. 701 and FY04 Supplemental Appropriations Section 1114.
  - Authorizes (but does not require) medical and dental screening and care necessary to ensure the member meets applicable medical and dental standards for deployment.
  - Screening and care may be provided any time after the member is "notified" that he or she is to be called or ordered to active duty for a period of more than 30 days.
  - Members must be "promptly notified" of their eligibility for such screening and care.
  - Members may not be charged for screening and care.

- SEC. 707.
  - DoD shall designate for each TRICARE region at least one person to serve full-time as the BCAC solely for members of the Reserve.

Summary